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The Role of the National Quality Forum (NQF) in the Quest for Transparency in U.S. Hospitals' Patient Safety Performance

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Perspective

Over the last decade, considerable attention has focused on addressing deficiencies associated with health care quality and patient safety performance in the United States. Despite this attention, the rate of improvement has been slow.(1-5) Although there are a number of contributors to this slow rate of progress, one factor is the lack of a uniform national quality measurement and reporting system. Recognizing that progress in improving quality and safety hinges on the availability of robust measures, many stakeholders have developed and disseminated a variety of quality measurement and reporting mechanisms in a piecemeal manner. The result: efforts to improve the efficiency, effectiveness, equity, timeliness, safety, and patient-centeredness of health care delivery services have been hindered by the lack of universally accepted measures.

This is where the National Quality Forum (NQF) is playing an increasingly important role. President Clinton's 1996 Advisory Commission on Consumer Protection and Quality in the Health Care Industry envisioned an entity that would be responsible for (i) implementing a comprehensive plan for measurement and reporting, (ii) identifying core metrics for measurement and reporting, and (iii) promoting the development of the core measures. The NQF, which was established in May 1999 by a White House–convened planning committee facilitated by then-Vice President Albert Gore (6), represents the culmination of this vision. Dr. Kenneth W. Kizer, NQF's first CEO and President, notes that NQF was structured as a unique public–private collaborative organization with a mission to promote the delivery of high-quality health care.

Since NQF's inception, the Institute of Medicine (IOM), federal task forces, and major stakeholders have recommended that it be tasked with managing a set of standardized quality measurements. These core

measures would provide a foundation for reporting systems that facilitate the capture of quality and patient safety practices critical to the prevention of medical errors, thereby supporting continuous improvement efforts throughout the United States.(7-9).

In 2003, NQF utilized a formal consensus development process to identify and release a list of 30 nationally recommended, evidence-based "Safe Practices" from a pool of 220 candidate safe practices. These 30 Safe Practices were deemed to be universally applicable in clinical care settings to reduce the risk of harm to patients.(10,11) It should be noted that a key characteristic of NQF's role in promoting safe practices is that the organization does not develop measures; rather, it is a neutral body that endorses measures. NQF continues to use a consensus-based review process to update the original 30 Safe Practices, based on the latest evidence for existing and proposed practices. Safe Practice updates were released in 2006 and 2009.(12)

However, NQF's mandate to find universal, "one-size-fits-all" measures may not be ideal. For example, we have found that certain of the original 30 Safe Practices are not applicable due to resource barriers in some hospitals.(13) Lower Safe Practice adoption rates are seen for resource-intensive practices such as implementing a computerized prescriber order entry system, ICU intensivist staffing, comprehensive pharmacist involvement in medication management, and referral of patients to high-volume hospitals. The barriers to adoption for these Safe Practices seem to be related to small hospital size, rural location, staffing shortages, and the lack of financial resources—constraints that may be ameliorated by economies of scale or certain models of health system management/ownership.

In contrast, research shows that some Safe Practices lack significant barriers to implementation. Features of the Safe Practice measures themselves, such as their low level of complexity or alignment with other salient patient safety measurement schemes—for example, mandatory Joint Commission accreditation—may promote adoption regardless of hospitals' geographic location, size, or other structural characteristics.(13-16)

Although the Safe Practices have been generally agreed upon by most stakeholders and have served as a unifying force, the current proliferation of other measures of quality and safety has convinced AHRQ, NCQA, CMS, JCAHO, and NQF to try to remedy the situation.(17-19) Experts like Dr. Janet Corrigan, the current President and CEO of NQF, worry that the field of quality measures is getting crowded and confusing.(17) Dr. Corrigan has written that one of the systemic problems with the current U.S. health care system is the lack of standardized performance measures that enable cross-institutional comparisons.(20) She stated that this creates two problems: "First, we do not know where the best performers are. Second, the best performers are not rewarded for their excellent work."(20)

The first problem is framed today as a "transparency" problem. Lacking standardized measures and publicly reported performance data, payers, the public, and policy makers are unable to determine how well physicians, care teams, and hospitals operate. This hinders their ability to select high-value providers. Likewise, providers themselves may not know how well, or how poorly, they provide health care services when compared with their peers, which stunts their ability to proactively improve the value of health care.

In the absence of a national approach to quality/safety measurement, local or regional stakeholders experience pressures to develop their own measurement and public reporting frameworks to address concerns about quality and cost. This has led to great variability in the approaches that local stakeholders employ to report quality and patient safety performance, exacerbating the transparency problem, as in many instances these stakeholders may "pick and choose" the clinical conditions, settings, and measures used for public reporting efforts. The result is apparent when we look at the variability in states' efforts. From state to state, there is high variability in the range of health care issues that are measured, publicly reported, and acted upon for improvement. For example, some states mandate the collection and public reporting of 28 NQF-endorsed serious reportable events ("never events"), while others collect subsets of these 28 events, and many do not require releasing this information publicly. Interestingly, at the national level, the Centers for Medicare & Medicaid Services started in October 2008 to withhold reimbursement for 10 health care–acquired conditions (HACs) that align with the "never event" concept. As NQF provides the foundation for metric standardization, we are likely to see more alignment in the future, with increasing levels of transparency, between state and national measurement efforts.

Transparent measurement of performance is necessary but not sufficient to drive quality improvement. Both consumers and providers need to be able to understand and act on performance data. Effective metrics will not only need to be practical, valid, reliable, and well-defined; they will also need to be "evaluable" by internal and external stakeholders in order to stimulate improvement.(21) For example, consumers may have difficulty understanding a measure of "iatrogenic pneumothorax" and what this may mean in their course of care. The science of reporting complex, highly technical information to consumers in a way that is easily understood ("evaluable") is slowly being recognized as an important feature of public reporting. NQF and others are evaluating the science of communication and are working on providing standardized guides that those involved in public reporting activities may use to promote health literacy.

NQF recognizes that the quality, "harmony," and "alignment" of metrics will be important characteristics that help bridge the gap between quality measurement/reporting and effective improvement. Although much work needs to be done, over time Dr. Corrigan envisions better aligned and harmonized metrics—that can "roll up and down" among physicians, teams, and hospitals. She also foresees NQF utilizing a more time-efficient consensus process, which will help NQF to achieve the goal of becoming the nationally recognized facilitator of continuous quality improvement for American health care quality.(17,22)

In its first decade, the NQF has successfully established itself as a key organization in the alphabet soup of national institutions focused on improving the quality and safety of health care. Continued success is likely to depend on widespread agreement among health care organizations that NQF-endorsed measures represent the single source of measures for public reporting and pay-for-performance programs. In turn, the ability of NQF to achieve this "trusted agent" position will depend on how well it does in rapidly evaluating candidate measures through its lenses of expert consensus and scientific evidence.

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